

Renegotiation of the Australian Health Care Agreements 2003-2008: from a State's perspective

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Abstract

The renegotiation process for the next Australian Health Care Agreements 2003-2008 presents an opportunity for State and Territory Governments to suggest reforms to improve acute and sub acute health services and health outcomes. Four key issues to Victoria are discussed, emergency departments and primary care interface, workforce planning, aged care and the continuum of care.

Australian Health Care Agreements 1998-2003

The Australian Health Care Agreements 1998-2003 recognise the joint funding responsibility of the Commonwealth and States to provide public hospital services to any Australian resident or eligible overseas resident as an inpatient, outpatient or for emergency care treatment. The Agreements define the States' primary role as the provider of acute health services, whilst the Commonwealth's primary role is to facilitate the funding of these services.

The current Agreements entrench the concept of Australia's pluralist health system by committing the States to ensuring that Australian residents and eligible overseas residents can elect to receive public hospital services as a public or private patient. Public patients are to have access to services on the basis of clinical need and within a clinically appropriate period. A national approach to health policy is also promoted throughout the Agreements and is founded on the basis of equity of access, standards of access and care, patient outcomes and the cost effective use of health resources.

The States achieved several positives through the current Australian Health Care Agreements. While previous agreements had provided additional funding for population growth and ageing, the current Agreement also provides additional funding for demand growth at a rate of 2.1 per cent per annum.

Through a variation to the current Agreements, access to the pharmaceutical benefits scheme is now available to non-admitted patients and admitted patients on discharge from public hospitals in Victoria. The arrangement enables a better quality of patient care at the point of discharge, which has been a priority for Victoria. This access to the scheme enables the risk of high growth in hospital supplied pharmaceutical benefits scheme medications to be shared by both the Commonwealth and the States. Consideration of additional funding to meet increasing health care costs for technological advancements in drugs and treatments could also be considered in the next Agreements.

The current AHCA have provided the States with approximately \$680 million over five years for quality funding. While the States are required to produce a strategic plan, the use of these funds is at the discretion of each jurisdiction. The Agreements formalise a national commitment, in partnership with clinicians and consumers, to health care safety and quality improvement and a general acknowledgement that some quality issues are better managed at a national level.

With these positives in mind, the current Agreements contain several flaws, due to the Agreement's acute inpatient focus, which ignores the effects of other health system demand pressures. Before proceeding with discussions on possible reforms, it is important to note that the AHCAs must provide adequate indexation for hospital and health care costs.

In the current AHCAs, the States and the Commonwealth were in dispute as to the appropriate level of indexation for the grant. An arbiter was appointed under the terms of the AHCAs and recommended that the appropriate level of cost indexation for AHCAs be CPI plus 0.5 per cent. The Commonwealth ignored the independent decision and decided to adopt wage cost index one as the indexation factor, which is generally more than 1 percentage point lower than the arbiters' recommendation. This decision will effectively reduce Victoria's health care grant by approximately \$220 million, over the five years of the current Agreement, and would have provided treatment for an additional 130,000 patients.

Interestingly, the Commonwealth Minister in a radio interview on 12 September 2002, defended the Commonwealth decision to allow private health insurance premiums to increase by up to CPI without having to obtain Government approval, and said 'One of the things we have to understand is that the health CPI has been in the last couple of years over double the CPI. Health costs increase at a much faster rate.' This failure to recognise inflationary health costs with an appropriate index for the AHCAs continues to adversely impact on public hospital services.

Possible reforms

The pluralistic structure of the Australian health system facilitates a diverse range of service providers and consumers. The AHCAs concentrate predominantly on acute hospital funding, a major component of the health system. However, hospitals are currently expanding the range of services they provide. The hospital walls are effectively being broken down and the role of the hospital redefined as more services are provided in a community setting. This has been encouraged not only by medical and information technology advancements but evidence of improved health outcomes and consumer preference.

The AHCAs renegotiation process offers an opportunity to consider the roles of public funded hospital services in the context of the continuum of care. Victoria believes issues relating to emergency departments and primary care interface, workforce planning, aged care and the continuum of care are central to these negotiations.

Emergency departments and primary care interface

There is an increasing demand for after hours and weekend primary care treatment through emergency departments. This increase in demand is particularly evident in outer metropolitan areas. This can be attributed to a shortage of General Practitioners and bulk billing services in the outer suburban areas and an increasingly realistic public perception that emergency departments are the only medical service available after hours. This perception is supported by a Commonwealth Department of Health and Ageing survey on 'Informed consumer preferences for after hours primary medical care (May 2002)' where some 77 per cent of respondents nominated emergency departments as the sole provider of after hours primary care.

Analysis of attendances at Victoria's major hospitals in 2001-02 found that patients presenting with primary care type cases increased by 5.4 per cent over the previous year and by around 20 per cent over the first four years of the current agreement. This is in contrast to the three year period to 2000-01 where total un-referred General Practitioner services in Victoria have increased by only 0.3 per cent. Victoria has also experienced a 3 per cent decline in the proportion of bulk billed GP services over this time period.

Victoria is addressing the issue of emergency demand hospital management through a range of strategies, funded outside of the AHCAs, by providing \$464 million in additional funding for a four year Hospital Demand Management Strategy. Strategies include coordinating emergency department doctors and nursing staff to fast track assessment and treatment and the establishment of medi-hotels to provide overnight accommodation for patients needing tests or day procedures. Aspects of the Hospital Demand Management Strategy could be incorporated into the scope of the next Agreements.

After hours primary medical care

The co-location of after hours primary care facilities within or adjacent to hospital emergency departments is generally seen as an effective strategy to relieve emergency department demand. The marginal cost of providing co-located General Practitioner services is minimal compared to establishing new practices and recognises both the existing provision of primary care services by emergency departments and the public's perception that they are the sole after hours primary care providers. This is seen as a particularly effective long term strategy in rural settings as it rationalises and centralises scarce nursing and medical resources through the co-located facilities and provides an environment for continuous General Practitioner / patient relationships.

The Commonwealth's guidelines specify that the co-located after hours clinic cannot be owned by the public hospital, nor can public hospital employees direct patients to utilise this service. As a means of facilitating efficient resource allocation, Victoria would prefer flexible funding and organisational arrangements for emergency departments and hospital based primary health care by allowing both public and private sectors to suggest referral to other primary care and general practitioner services.

Another factor that may address the demand for primary care services is incentives for private hospitals' emergency departments to treat such patients. This could be achieved by allowing private health insurance funds to cover out of pocket expenses associated with facility and diagnostic fees charged for private emergency department services.

Private health insurance subsidy

Consideration should be given to the effectiveness of the Commonwealth's \$2 billion private health insurance subsidy. The subsidisation of the private health fund sector was intended to provide relief to public acute health services. While it is acknowledged that private hospitals have experienced an increase in patient demand since the introduction of the subsidy, there has been no real demand relief on public hospital services in Victoria, with some services, such as primary care type presentations at emergency departments, experiencing increases in demand.

Approximately \$460 million of the private health insurance subsidy is used to subsidise private ancillary services, which have little impact on reducing acute hospital demand. Subsidised ancillary services include private dentistry services, gym memberships and alternative therapy, for which there is no Commonwealth public funding equivalent. In addition to not relieving public hospital demand, utilising the subsidy for ancillary services does not provide a balance of services across private and public hospital sectors. It is important that a similar level of funding be made available for public hospital services.

In order to avoid the Commonwealth's Lifetime Health Cover loadings many consumers have purchased insurance with a front-end deductible component. It is advantageous for holders of these front-end deductible policies to be treated as a public patient, thus avoiding any excess charges. This is supported by a Victorian Department of Human Services survey in 2001 on utilisation of private health insurance in Victorian public hospitals. The survey revealed that 55 per cent of privately insured patients presenting at public hospitals fail to declare their insurance status and are subsequently treated as public patients. The forgone revenue to Victoria for treating subsidised insured patients as public patients in 2001-02 is estimated at \$75 million.

Victoria is committed to the universal health system and the right of privately insured people to utilise public hospital services as a public patient and the choice to be private patients in either public or private settings. However, in order to facilitate the subsidy's intention to provide demand relief to the public hospital system, private patients should be able to access a wider range of hospital services, such as ambulatory and non-admitted services, through their private health insurance without the financial disincentive to declare their insurance status. Victoria would support strategies that encourage the use of private health insurance to increase private revenue to public hospitals.

Workforce

The next AHCA's are seen as an appropriate forum to acknowledge workforce shortages in the health sector and to pursue workforce development. The impending national crisis, resulting from shortages of acute and aged care nursing staff, General Practitioners and specialist services, should be managed with a national focus. This would ensure an efficient use of current resources and expediency in implementing strategies to manage

this issue. Workforce issues such as training and education, data collection and research to inform future workforce planning could also be addressed through the next Agreements, with consideration given to the work currently being conducted by existing national bodies.

In Victoria, the Government's Growing Victoria Together highlighted the delivery of high quality, accessible human services as a key priority for the next decade, with an emphasis upon improving local access to essential health, aged care and community services, particularly in rural and regional communities. Victoria has spent around \$7 million over the past two financial years for nurse recruitment and professional development packages. There has been considerable success in the Victorian nursing initiatives, with over 3300 additional full time nurses recruited into the Victoria public health system across all sectors of nursing, which included over 2000 former nurses back to the system. This was achieved via refresher re-entry programs that enable nurses to return to the profession in a supported manner.

Funding of \$700,000 has been made available for students within rural and remote areas to ensure that they have access to quality clinical placements during their undergraduate program. Approximately 1000 students have been placed to date. It is intended that providing this support to students will result in decreased attrition rates. This initiative also provides an investment in improving the ability of rural health services to meet the needs of their communities.

Funding of \$1.4 million has also been made available for over 900 additional Division 2 nurses, to better support the Division 1 nurse workforce across all settings including aged care. A nurse back injury prevention project has led to significantly reduced injury rates and contributes to overall retention of nurses and improves continuity of care for patients. Victoria has provided over \$6 million in funding over the last five years.

Despite the success of the recruiting campaign, Victoria is unable to train enough nurses to meet demand due to a lack of Commonwealth funded university places. The number of university places has decreased by 14 per cent in the last decade, despite demand for nurses increasing by 35 per cent in the same time period. Any initiatives by the States to increase nurse numbers cannot succeed if the Commonwealth will not provide adequate funding to enable more nurse placements at universities. While demand for university places has increased as a result of recruiting campaigns, university places for nursing are decreasing. In Victoria only 63 per cent of nurses who nominated for an undergraduate nursing course as first preference were accepted in 2002.

Victoria funds a number of programs to attract health care providers to rural and regional Victoria, at a cost to Victoria of over \$7 million in 2001-02. The three-year Rural Clinical Skills Initiative provided grants of \$1.5 million to each of Monash and Melbourne Universities for student accommodation and teaching infrastructure in rural clinical schools. The Victorian rural recruitment scheme for overseas trained doctors placed 40 General Practitioners in previously vacant positions at a cost of over \$400,000. The Victorian Advanced Training in General Practice Program received over \$350,000 while the Universities Rural Health Consortium received \$300,000.

Victoria has contributed more than \$1.2 million in supplementing Commonwealth funding to encourage opportunities for medical specialist training outside of metropolitan Melbourne. By training in regional and rural hospitals, these future medical specialists are encouraged to consider careers serving rural communities. These trainees are experienced doctors approaching their final years of specialist training and play a valuable role in providing medical specialist services in regional and rural areas. There is also over \$2 million being provided by Victoria in 2001-02 to attract and retain allied health professionals in rural areas.

Aged care

Intergenerational report

Following publication of the Commonwealth's recent Intergenerational Report, there has been debate about the impact of ageing on State and Commonwealth Budget positions. However, ageing contributes less than 20 per cent of the increase in health-care spending projected in the report, with more than 80 per cent due to the use of new technology, drugs and new treatments. (Victorian Treasurer Brumby's presentation to the Committee for Economic Development in Australia, 20 August 2002).

Although the Commonwealth highlights the fiscal pressure on its budget, the Report forecasts Commonwealth budget surpluses until 2014-15, with Commonwealth revenues expected to keep track with the economy. Victoria does not have this luxury as the projected fiscal pressure arising from health care costs, increasing at CPI plus 1 per cent, is compounded by slow growth in State revenue, particularly with the Commonwealth GST payments falling behind growth in the economy. Also, as people age, a higher share of their spending will go into GST-exempt areas such as health care and food.

A Commonwealth paper, 'Technology, Health and Health Care', Department of Health and Aged Care, Occasional Papers: Health Financing Series, indicates that for the period to 2016 there is a projected increase in expenditure of 3.9 per cent per annum. This is assuming continuation of recent real growth rates. The amount resulting from population growth is 0.9 per cent and ageing is 0.5 per cent. The residual is due to increased demand for or supply of services at 2.5 per cent per annum.

There is a challenge to be met, but it is one more related to community expectations and increased demand and supply than ageing. It is important that the growth funding in the current Agreement be maintained to enable the public hospital system to cope with these pressures.

Older patients awaiting residential aged care

There are currently around 600 patients who have been assessed as requiring residential aged care services but are occupying public hospital acute / sub acute beds and interim care places, due to poor access to such care. Victoria supports the importance of achieving and maintaining the operational level of residential aged care at the benchmark level and ensuring places are operational within a reasonable timeframe and equitably distributed across geographic regions. Commonwealth funded aged care beds are approved against the Commonwealth's benchmark of 90 beds per 1000 persons aged 70 years and over. Despite the Commonwealth approving beds in accordance with this benchmark, Victoria is currently 5000 operational beds below this benchmark, due to the time lag in constructing new facilities.

Demand management and service provision for this growing demographic could be facilitated through the development of appropriate post-acute and sub-acute care that encompasses transition care, rehabilitation, and step-down care. In particular, sub-acute service levels should keep pace with the growth in this target population, and move towards planning benchmarks. Community based service provision would also be favoured as a means of keeping acute beds available for acute type patients.

AHCAs could also cross-reference other programs and provide the medium to facilitate shared responsibility between programs and agencies. The continuum of care for older Australians will be better achieved through accepting the inter-dependence of health and aged care programs.

The recent Final Report of the Review of Commonwealth-State funding carried out by Professor Ross Garnaut and Dr Vince Fitzgerald included a recommendation that there be a single broad banded Specific Purpose Payment for health and aged care. It is proposed that this would broadband AHCAs, Home and Community Care, highly specialised drugs, blood transfusion services, public health and some other smaller Specific Purpose Payments.

The continuum of care

Information technology offers considerable scope for gains in the overall health system and the continuum of care. Information and information technology are key foundations for the greater coordination of care, as well as better information sharing, more appropriate service provision and greater empowerment of consumers. Information technology is seen as pivotal to the expansion of health services as it can: deliver an evidence base into practice via easier access to medical reference tools; provide better community access to information; enable continuous care relationships between patient and clinician; and facilitate a flexible service delivery environment for monitoring illness and patient self management.

The next Agreements should be used to establish a health care environment that supports a continuum of care. Victoria believes there is a need for innovation in service planning and better coordination between community care, primary care, acute care, sub acute, transitional care, and residential care. In practicality this could include improved coordination of services from public hospitals to residential aged care or funding models that allow integrated patient care between public hospitals and the community.